

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked at item 18 shows any injury, or other traumatic event, this must be examined and noted at item 21d.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 0 0			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Alexander					Anderson	5 4 81						9:40P M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH	DAY	YEAR	91			MONTHS	DAYS	HOURS	MIN		
9 13 89								YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Lonaconing, Md		USA					Garrett			MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Oakland		Dennett Road Manor Nursing Home		Textile Worker											
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Md		Allegany	Lonaconing				Watercliffe Street								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
John				Anderson	Isabelle					Killer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
(If Yes, give war or dates)				Adrian Anderson			Brookville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days			
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u>												Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old CVA															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5-1-81 19		12-13-1978 19		5-1-81 19			19								
say the deceased alive on 5-1-81 19		and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated (I) <input checked="" type="checkbox"/> did <input type="checkbox"/> not view the body after death													
22b. SIGNATURE				DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
James H. Feaster, Jr., M. D.										5-4-1981					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE				
Eichhorn Funeral Home, 8 E. Main St.				Lonaconing, Md.											
24. FUNERAL DIRECTOR NAME												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

документ

запись

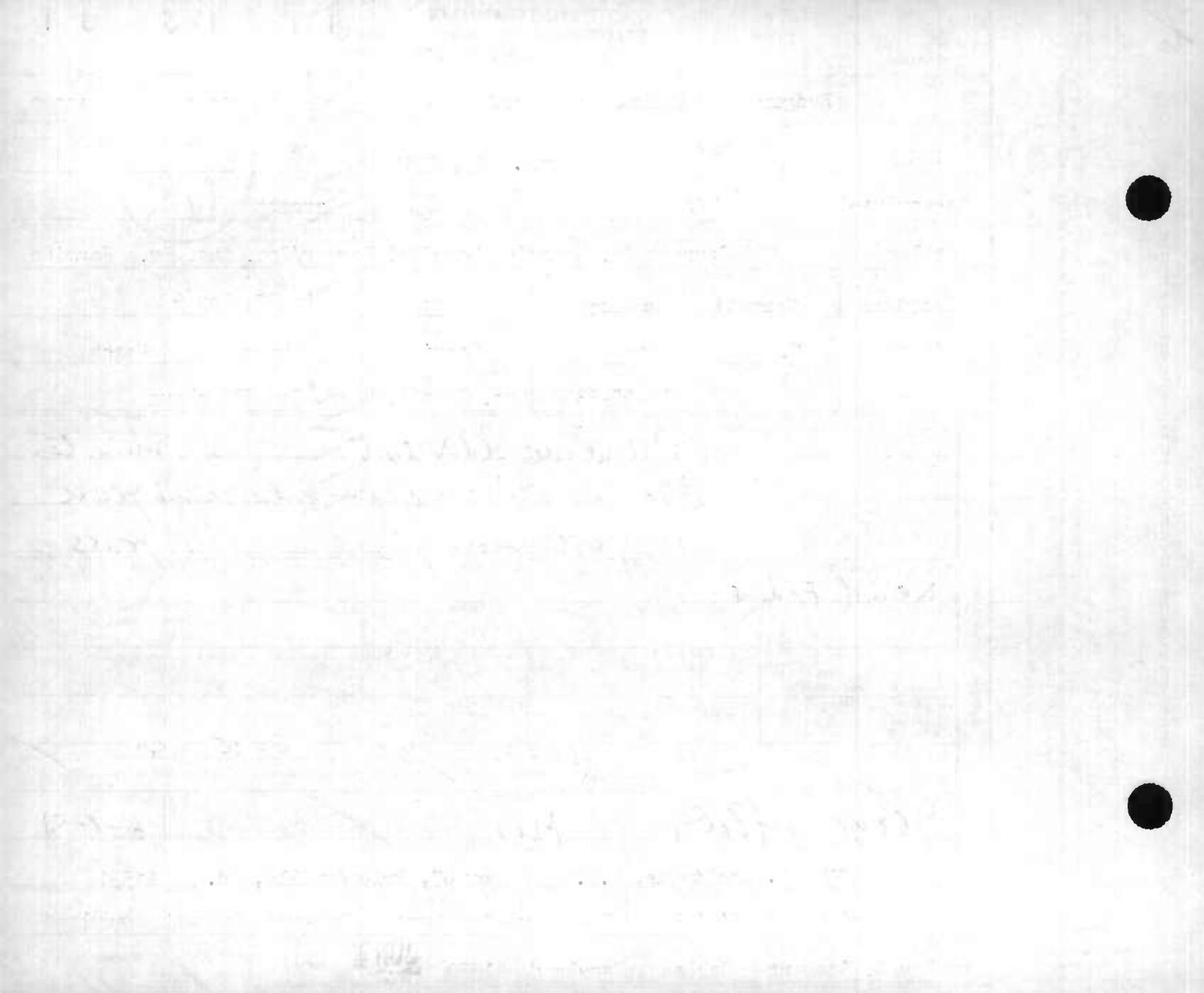
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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 0 1					
1 - FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)		FIRST Rodger		MIDDLE William		LAST Bond		2a. DATE OF DEATH May 30, 1981		MONTH JUN		DAY 4		YEAR 1981		2b. HOUR 1030P M	
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 19, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett		10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA-Garrett Co. Memorial Hospital		12a. USUAL OCCUPATION Farmer/Sch. Bus. Op.		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN McHenry		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route \$2, Box 9									
14. FATHER'S NAME FIRST George		MIDDLE E.		LAST Bond		15. MOTHER'S MAIDEN NAME FIRST Carrie		MIDDLE Rebecca		LAST Veach							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-05-5338		17. INFORMANT Mrs. Edna A. Bond, See #13 above													
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029				Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic Cardiovascular disease years minutes													
				DUE TO, OR AS A CONSEQUENCE OF Hypertension years													
19a. DATE OF OPERATION 2/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MEDICAL CERTIFICATION		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) George B. Stoltzfus, M.D.		21f. LOCATION STREET Box 67, Friendsville, Md. 21531		CITY OR TOWN McHenry, Garrett, Maryland		COUNTY McHenry		STATE Garrett, Maryland							
22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1981, to 5-25, 1981, that (I) (we) lost saw the deceased alive on 5-25, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.		22b. SIGNATURE George B. Stoltzfus, M.D.		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-1-81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Stoltzfus, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 6/2/81		23c. NAME OF CEMETERY OR CREMATORIAL Oak Grove Cemetery		23d. LOCATION CITY OR TOWN McHenry, Garrett, Maryland		COUNTY McHenry		STATE Garrett, Maryland							
24. FUNERAL DIRECTOR NAME Bradley A. Stewart		ADDRESS Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRAR JUN 4 1981		25b. REGISTRAR'S SIGNATURE McHenry											



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 | 1 | 3 4 0 2

1- FOR STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST						2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
(TYPE OR PRINT)		Junior Gilbert BOWMAN						OF ESTI- DEATH MATED <input checked="" type="checkbox"/>		5 24 19 81 5P M	
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		White		Apr. 13, 1928		53 yrs.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA								Garrett	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Oakland		Star Route #2, Box 154						Janitor		Head Start	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Garrett		Oakland				Star Route #2, Box 154			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
John		Albert		Bowman		Ethel		Lydia		Bowser	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		ADDRESS	
Yes		WW II						217-28-0042		Mrs. Daisy Stiles, Oakland, Md. 21550	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, Massive</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
4374 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Ventricular Fibrillation</u> Minutes Due to, or as a consequence of (c) <u>(Aspiration of Stomach Contents--Terminal)</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER						DATE SIGNED 5-26-81			
EXAMINER'S NAME (TYPE OR PRINT)		James H. Feaster, Jr., M. D. ADDRESS 107 S. 2nd. St., Oakland, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		COUNTY STATE	
burial		5/29/81		Garrett Co. Mem. Gardens				Oakland, Garrett, Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE DEATH CERTIFIED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bradley A. Stewart		Oakland, Maryland 21550						1981		<i>[Signature]</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, RELEASE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR USE.
TO FUNERAL DIRECTOR: PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/76

SV 2002 - additional responses

initially no added

(Gentleman—added "except the following")

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be

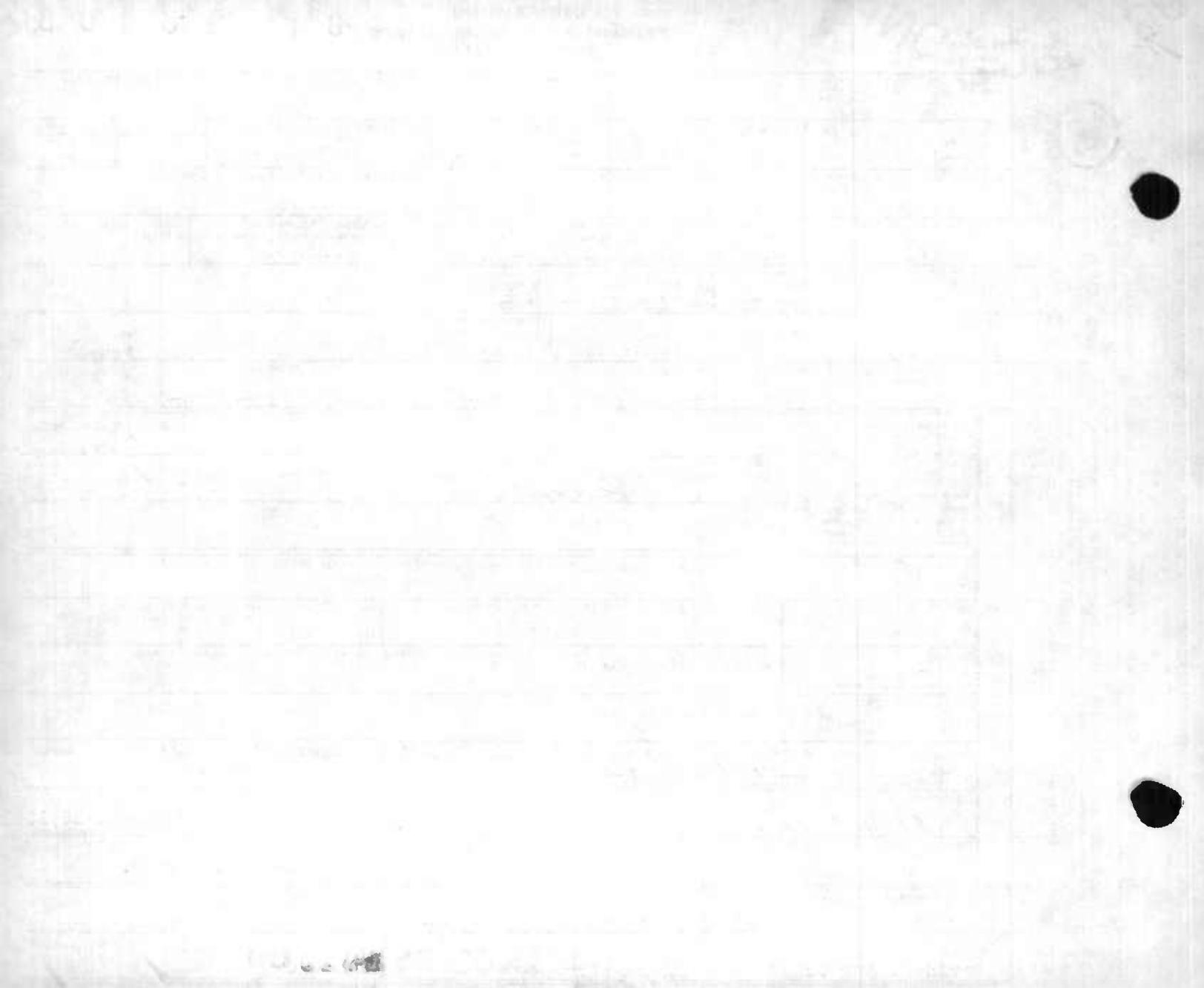
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IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		April 27, 1981				
A. Ethel Boyce												
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS		
Female		White		July 5 1893				87 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				
W. Va.		U.S.A.						Garrett MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Oakland		Cuppett Weeks Nursing Home						Housewife				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MD		Garrett		Kitzmiller				Main Street				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Benjamin				Sharpless		Ellen				Paugh		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN DEATH AND CERTIFICATION						
no		217-05-9488		David A. Burdock		Years						
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerosis</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arthritis</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 25</u> , 19 <u>64</u> , to <u>Apr. 27</u> , 19 <u>81</u> , that (I) (we) lost sow. the deceased alive on <u>Apr. 27</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>AS Mance M.D.</u>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED April 28, 1981				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andrew E. Mance, M.D.		22e. ADDRESS 3 South Third St.- Oakland, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPEC#) Burial		23b. DATE April 30, 81		23c. NAME OF CEMETERY OR CREMATORIAL T.O.O.F. Cemetery		23d. LOCATION CITY OR TOWN Elk Garden		COUNTY		STATE Mineral WVA		
24. FUNERAL DIRECTOR NAME David A. Burdock		ADDRESS Kitzmiller, MD				25a. DATE REC'D. BY REGISTRAR May 15 1981		25b. REGISTRAR'S SIGNATURE				

BP

DHMH-16 25M
(VRA 15, 4) 1/79

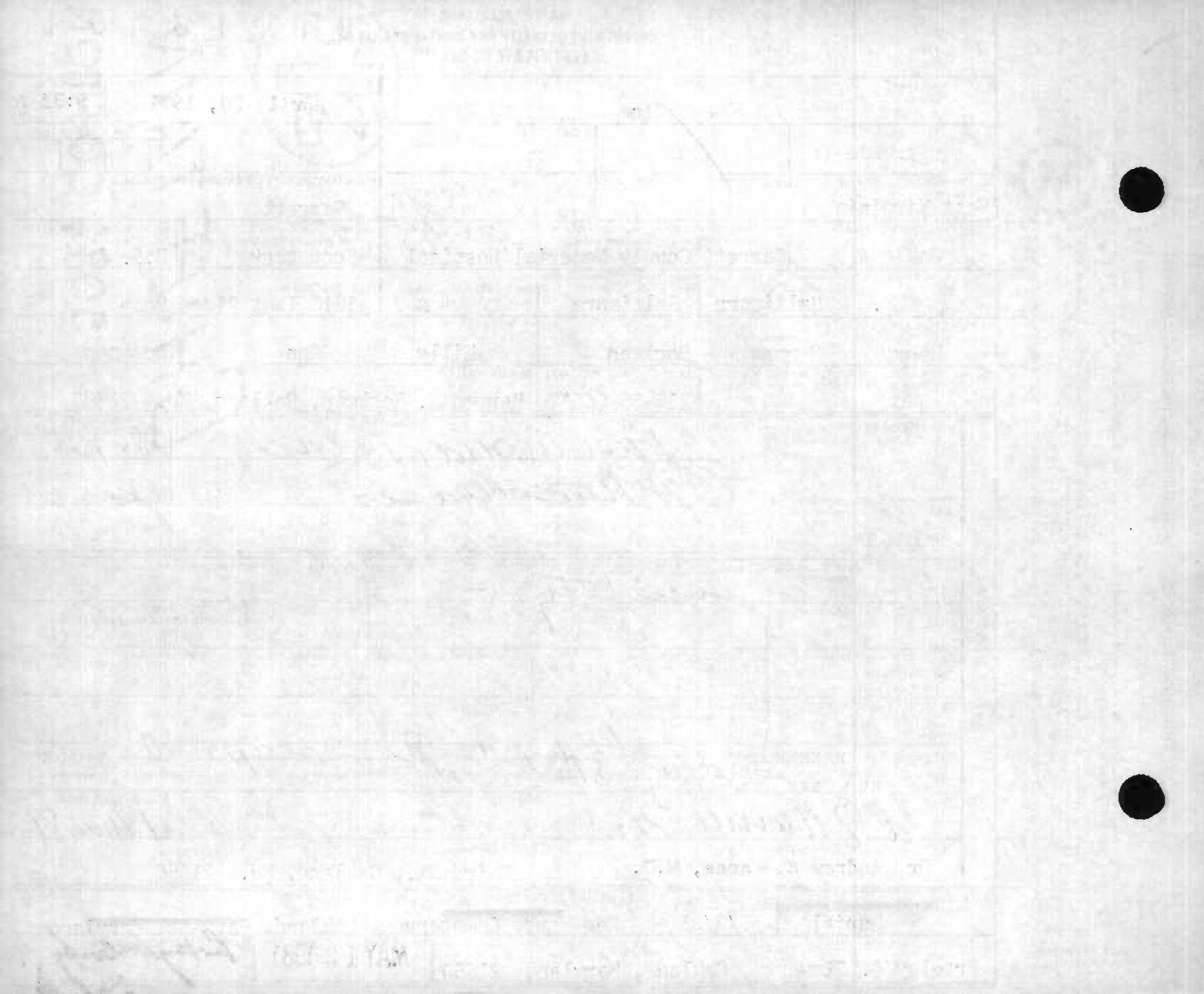


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												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Minnie			Charlotte	BREUNINGER		April 30, 1981						9:35 A M	
3. SEX			4 RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female					April 19, 1893	88			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
West Virginia			USA								Garrett MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Oakland			Garrett County Memorial Hospital			Secretary			U.S. Army				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md.			Baltimore	Baltimore				1516 Tent Ridge Road					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Henry			Herman		Beckman	Lilly			Ann Thompson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			215-36-9651D			Herman H. Beckman, Oakland, Md.			21550				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Meconormia, Labor</i> 4409 APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Meconormia, Labor</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Meconormia, Labor</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Meconormia, Labor</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Meconormia, Labor</i>												BETWEEN ONSET AND DEATH Weeks	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) <input type="checkbox"/> attended the deceased from above, (I) <input type="checkbox"/> did (I) <input type="checkbox"/> view the body after death.			July 11, 1981			to 300pm 1981			that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>July 11, 1981</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated (I) <input type="checkbox"/> did (I) <input type="checkbox"/> view the body after death.				
22b. SIGNATURE <i>Dr. Andrew E. Mance, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>May 12, 1981</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Andrew E. Mance, M.D.			22e. ADDRESS Third St., Oakland, Md. 21550										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 5/3/81			23c. NAME OF CEMETERY OR CREMATORIAL Red House Cemetery			23d. LOCATION CITY OR TOWN Oakland, Garrett, Maryland				
24. FUNERAL DIRECTOR NAME Bradley A. Stewart			ADDRESS Oakland, Maryland 21550			25a. DATE REC'D. BY REGISTRAR MAY 12 1981			25b. REGISTRAR'S SIGNATURE <i>Bradley A. Stewart</i>				

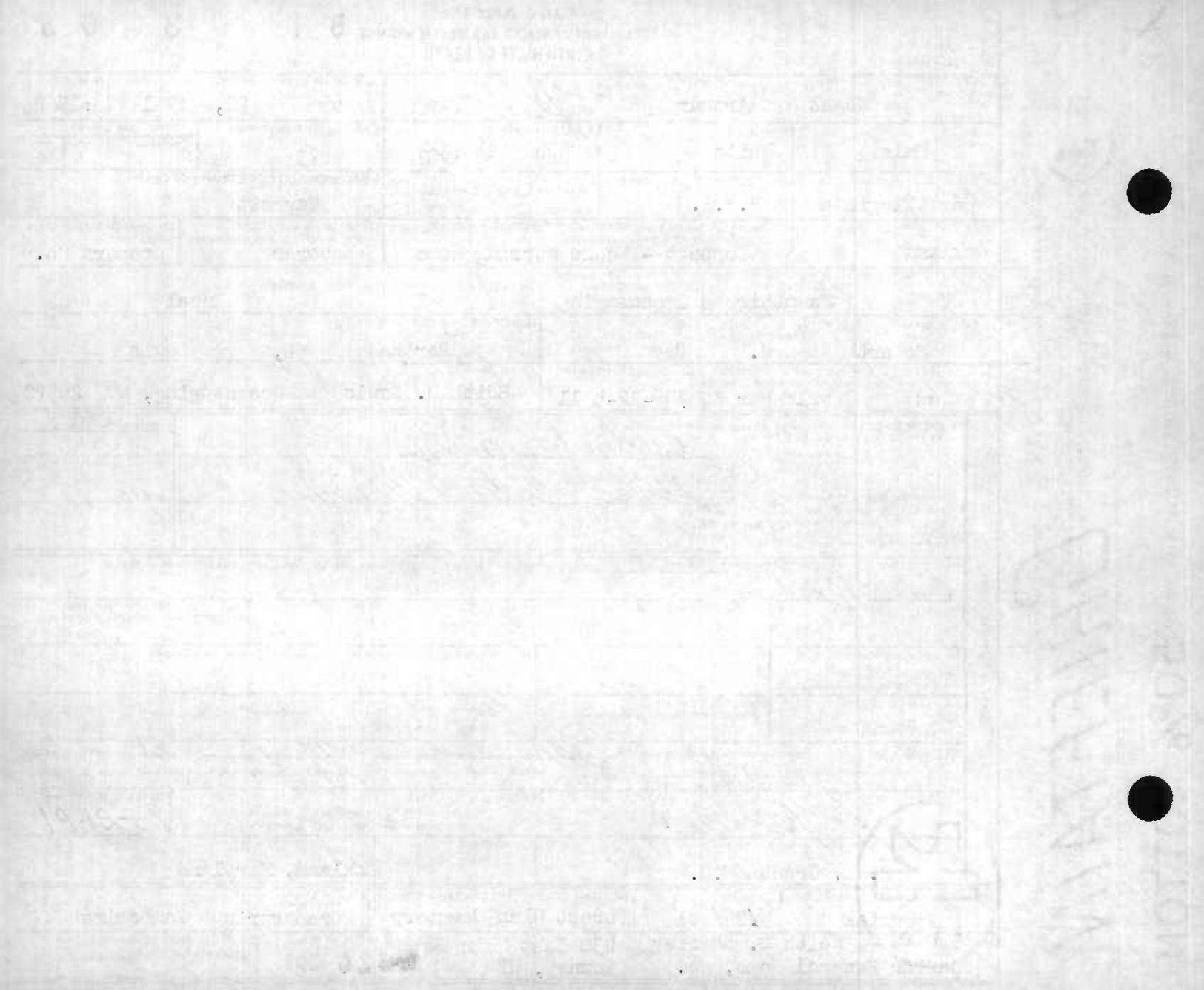


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

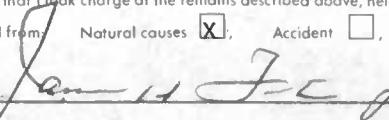
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 0 5	
											REG. NO.		
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			James Arthur Day			May 21, 1981			8:15 P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS	
Male			White			May 30 1907			73			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia			U.S.A.						Garrett			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Oakland			Cuppett - Weeks Nursing Home			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Laborer			Koppers Co.	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET ADDRESS				
WV			Hampshire			Greenspring			Rural				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
Robert J. Day			Bertha E. Lewis			Yes World War II			705-12-4911			Edith M. Lewis Greenspring, WV 26722	
18. CAUSE OF DEATH (Enter only one cause per line for item 18, part I, and 18, part II.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 42912 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1mo.</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic C.V. Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)												<i>yes</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>COPD.</i>													
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>5-20</i> 19 <i>81</i> , to <i>May</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>5-20</i> 19 <i>81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <i>B. L. Grant</i>			DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED -- <i>5-21-81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. L. Grant M.D.			22e. ADDRESS Oakland, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/24/81			23c. NAME OF CEMETERY OR CREMATORIAL Forest Glen Cemetery			23d. LOCATION CITY OR TOWN Greenspring		COUNTY Hampshire	STATE WV	
24. FUNERAL DIRECTOR NAME Keith S. Shaffer Shaffer Funeral Home, Inc.			ADDRESS 230 East Main St. Romney, WV			25a. DATE REC'D. BY REGISTRAR May 26 1981			25b. REGISTRAR'S SIGNATURE <i>John Shaffer</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3406								
1- FOR STATE REGISTRAR			I. DECEASED NAME FIRST Paul						MIDDLE Dana			LAST FEATHER			2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 12 19 81 610P					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 71 yrs.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 5 12 19 81 650P						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? USA						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Garrett					
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route #1, Box 64						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ironworker						12b. KIND OF BUSINESS OR INDUSTRY Construction					
13a. STATE Md.			13b. COUNTY Garrett			13c. CITY OR TOWN Oakland			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route #1, Box 64									
14. FATHER'S NAME FIRST Burt			MIDDLE -----			LAST Feather			15. MOTHER'S MAIDEN NAME FIRST Effie						MIDDLE -----			LAST Livengood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 382-07-5158						17. INFORMANT Mrs. Iva V. Feather, See #13 above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																				
ACTUAL SIGNATURE 												TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER			DATE SIGNED 5-12-1981					
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M.D.			107 S. 2nd St., Oakland, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 5/15/81			23c. NAME OF CEMETERY OR CREMATORIAL Terra Alta Cemetery						23d. LOCATION CITY OR TOWN Terra Alta, Preston, West Va.								
24. FUNERAL DIRECTOR NAME Bradley A. Stewart			ADDRESS Oakland, Maryland 21550			25a. DATE REC'D. BY REGISTRAR MAY 19 1981						25b. REGISTRAR'S SIGNATURE 								
BP _____																				
DHMH - 17 (VR A15 ME (5)) 15M 7/76																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										81 13407				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
I DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	May 31, 1981							1815 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		MONTH	DAY	YEAR	83		MONTHS	DAYS	HOURS	MIN.		
7d BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Kentucky		U.S.A.								Garrett Co. MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Oakland		Garrett Co. Mem. Hospital								Nurse				
12 STATE 13 COUNTY		14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS				
WV		Frank Franklin		Dorie Boles		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				100 Caldwell St.				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				ADDRESS				
No		236-34-5969		Mrs. Carl Franklin, 100 Caldwell St., Terra Alta, WV 26746		Respiratory Failure								
4409		DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Vascular Disease												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>James Beeson MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-1-81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-3-81			23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove Cemetery			23d. LOCATION CITY OR TOWN RT. #2, Terra Alta, Preston COUNTY			STAFF		
24. FUNERAL DIRECTOR <i>John K. Whitehead</i>			ADDRESS Terra Alta, WV 26746			25a. DATE REC'D. BY REGISTRAR JUN 10 1981			25b. REGISTRAR'S SIGNATURE <i>Henry McCoyle</i>					
BP _____														
DHMH - 16 50M 1/81 (VRA 15, 4)														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		05 - 28 - 81			0155 A M			
Macie Izetta GOEHRINGER														
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female			White			Dec. 4, 1899		81 YRS.						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD			
Maryland			USA					Garrett County,						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Oakland			Garrett Co. Memorial Hospital							Asst Dietician			Hospital	
13a STATE Maryland			13b COUNTY Garrett		13c CITY OR TOWN Friendsville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS P.O. Box 221, Water St.					
14 FATHER'S NAME FIRST Franklin			MIDDLE Humberson			LAST		15. MOTHER'S MAIDEN NAME FIRST Annie			LAST Guard			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]			16b SOCIAL SECURITY NO. No ---			17 INFORMANT Ivan O. Humberson, Friendsville, Md. 21536		ADDRESS P.O. Box 134						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960			Respiratory Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive Pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from July 19 77 to 5-28 19 81, that (I) saw the deceased alive on May 27 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b SIGNATURE Dr. George Stoltzfus			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 5-28-81					
22d PHYSICIAN'S NAME (FM OR PF)			22e ADDRESS Box 67, Friendsville, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 31, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Humberson Cemetery			23d. LOCATION CITY OR TOWN Friendsville, Garrett, Md.			COUNTY STATE		
24 FUNERAL DIRECTOR Doris Neaseen			ADDRESS Grantsville, Md.			25a. DATE REC'D. BY REGISTRAR JUN 5 1981			25b. REGISTRAR'S SIGNATURE Larry McHenry					

2010 RELEASE UNDER E.O. 14176

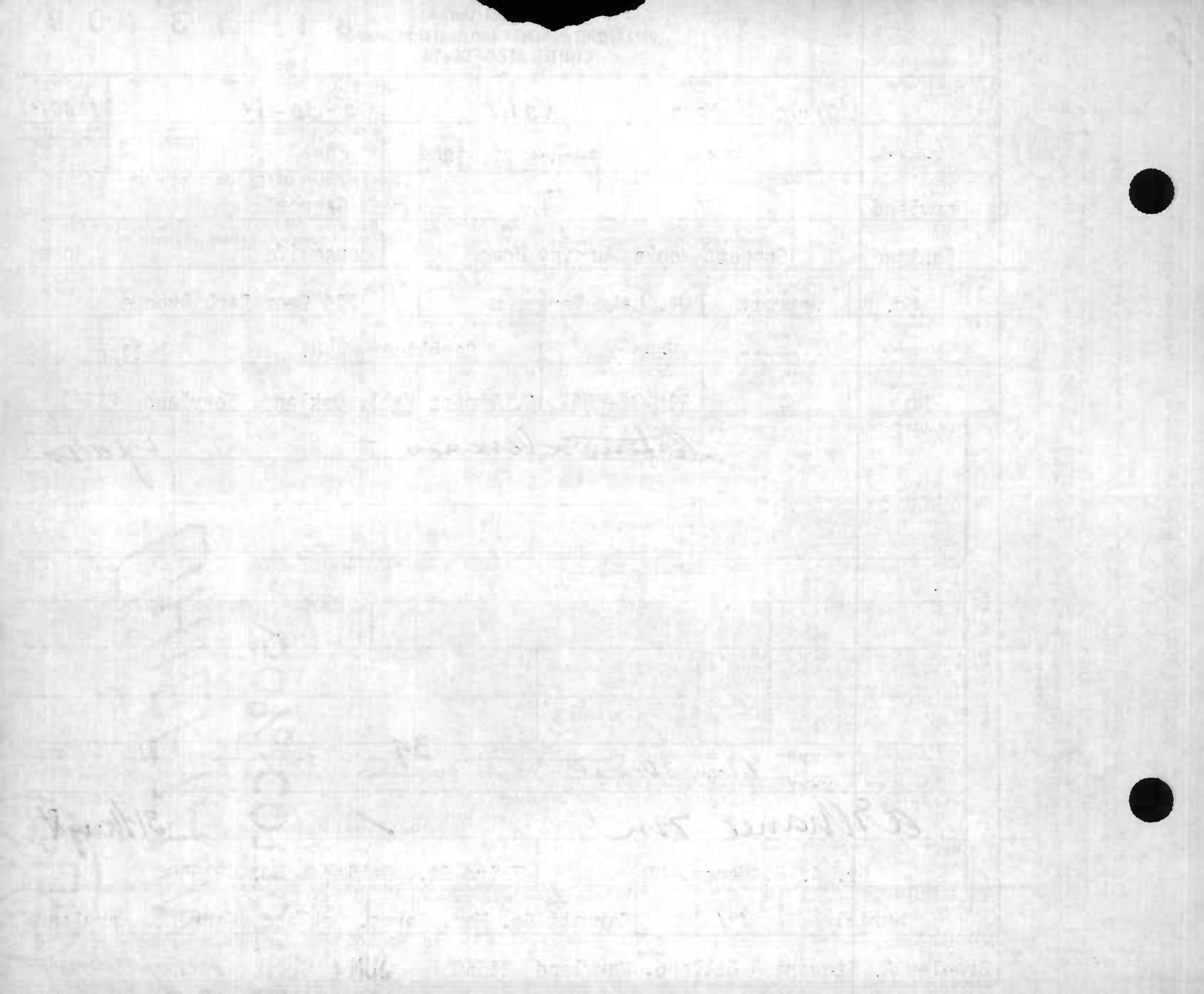
MC16 Tagline Possible

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 1 3 4 0 9			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Carrie				Mann	Kahl	5-30-81						1:00 P.M.			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		# UNDER 24 HRS		
Female			White		August 27, 1898			82			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MONTH DAY YEAR			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Garrett							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Oakland			Cuppett-Weeks Nursing Home					Housewife			Home				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md.			Garrett		Mt. Lake Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		716 Deer Park Avenue						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
Henry			-----		Mann	Caroline			H.		Mellon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			218-38-0352			C. Thomas Kahl, Oakland, Maryland 21550									
18. CAUSE OF DEATH (Enter only one cause per line for item 18, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis -</u> <u>4409</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <u>XXXXXX</u> attended the deceased from <u>19 29</u> to <u>5-30</u> 19 <u>81</u> , that (II) <u>(X)</u> lost saw the deceased alive on <u>May 30 19 81</u> , and that in (my) <u>(X)</u> opinion death occurred on the date and hour and from the causes stated above, (II) <u>(X)</u> did <u>XXXXX</u> view the body after death.															
22b. SIGNATURE <u>Archane M</u>												22c. DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. A. E. Mance, MD</u>												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. ADDRESS <u>Third St., Oakland, Md. 21550</u>												22f. DATE SIGNED <u>31 May 81</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
burial			6/2/81			Garrett Co. Mem. Gards.			Oakland, Garrett, Maryland						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Bradley A. Stewart			Oakland, Maryland 21550			JUN 4 1981			<u>Hilary McCreedy</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR										8113410		
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
		Florence	Marie	KINDSCHI	05 - 19 - 81					0340 AM		
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		11 - 21 - 00		80		MONTHS DAYS		YEARS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Wisconsin		USA						Garrett				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Oakland		Garrett County Memorial Hospital							Housewife		Home	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS				
Md.		Garrett		Mt. Lake Park				815 Heritage Drive				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		Wenzel	Joseph	Yeske			Ida	Anna	Iehl			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS						
No		214-74-3687		Mr. Grant G. Kindschi. See #13 above								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) 5315		10+day										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost		DUE TO, OR AS A CONSEQUENCE OF (b), ,Perforated Gastric Ulcer DUE TO, OR AS A CONSEQUENCE OF (c)										
19 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
5.9.81		establish cause of death		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED AT WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a I certify that (I) <input checked="" type="checkbox"/> attended the deceased from saw the deceased alive on 5-18 1981, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did <input checked="" type="checkbox"/> view the body after death.				19 67		to May 19 81						
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										5.19.81		
Dr. Bowie L. Grant												
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		COUNTY		STATE		
burial		5/22/81		Jefferson Mem. Cem.		Pleasant Hills, Allegheny, Pa.						
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Bradley A. Stewart		Oakland, Maryland 21550										

1990-1991
1991-1992

INDUSTRIAL DESIGN

88 - 18 - 1

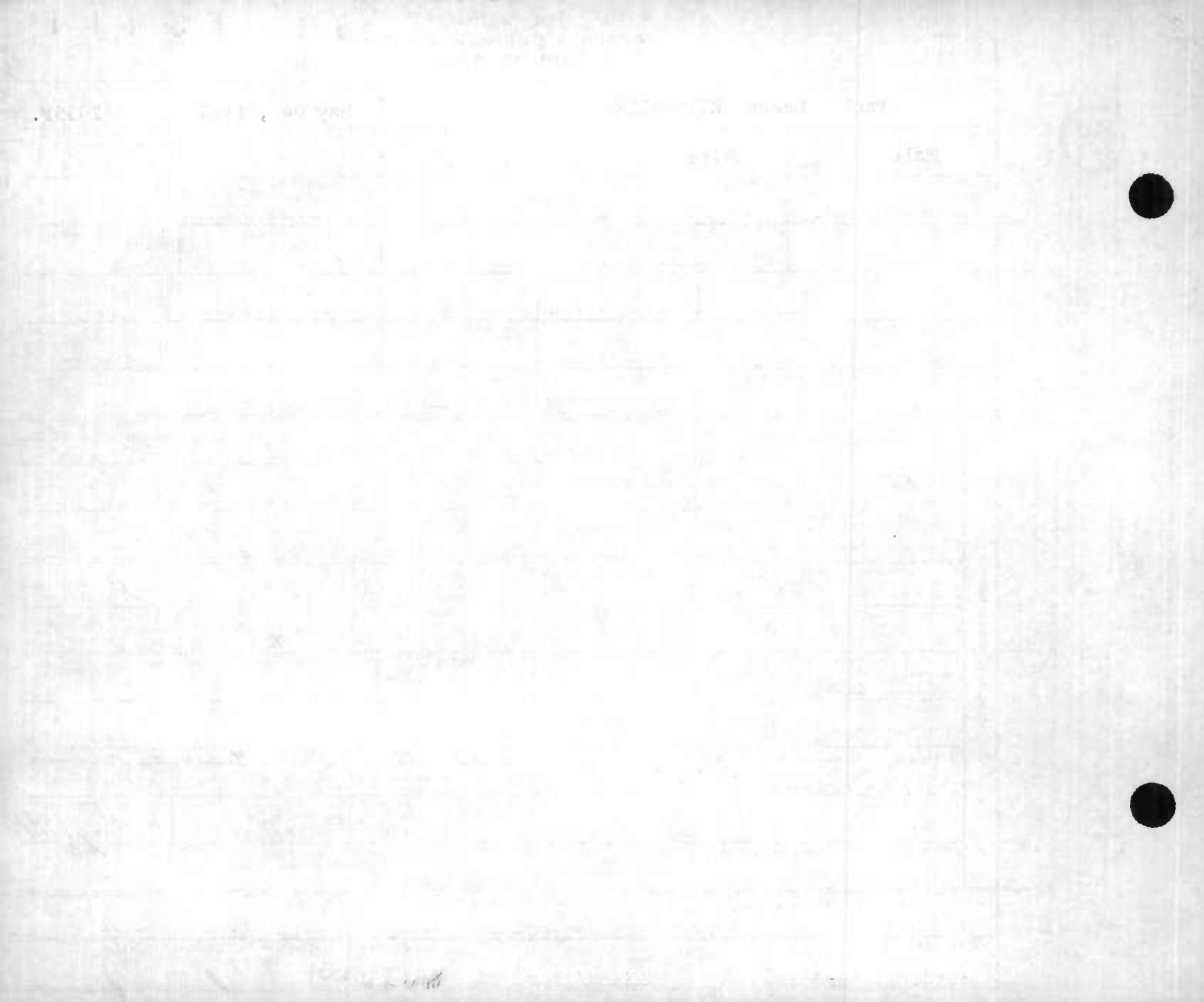
2006-10-01 10:10:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8113411			
										REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Paul Oscar KITZMILLER						May 04, 1981			2055 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		April 4 1898			83 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		Garrett County MD				
West Virginia		U.S.A.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Oakland		Garrett County Memorial Hosp.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MD		Garrett		Kitzmiller					Spring Street				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
James		O.		Kitzmiller			Ida		F.		Brinegar		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no		232-09-9245					Cerebral Vascular Accident		Minutes				
4292		Due to, or as a consequence of (b) Hypertensive Cardiovascular Disease								Unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												Unknown	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from <u>March 13, 1981</u> to <u>May 4, 1981</u> , that (I) <input type="checkbox"/> (we) last saw the deceased alive on <u>May 4, 1981</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <i>Herbert H. Leighton, MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 5 May 1981					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
Herbert H. Leighton					Oakland, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		5/7/81		Fairview Cemetery			Table Rock		Garrett		MD		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
David A. Burdock		Kitzmiller, MD			MAY 15 1981		<i>DA Burdock</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be surrendered within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be completed.

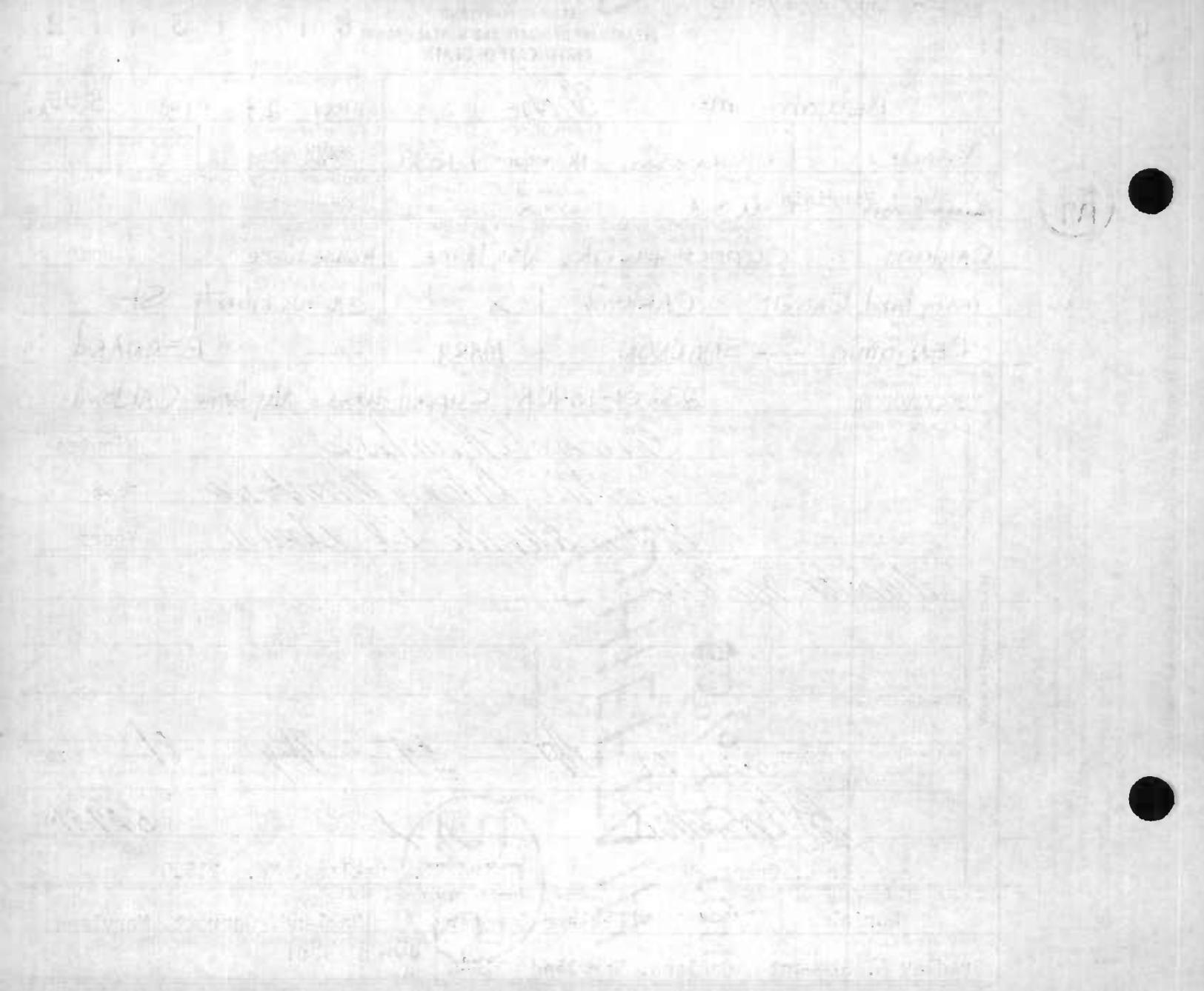
Item 7a g556 6/25/81 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 | 1 | 3 4 | 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<u>Beulah</u>			<u>May</u>	<u>Shobe</u>		<u>May</u>	<u>27</u>		<u>1981</u>	<u>5.55 A.M.</u>			
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
<u>Female</u>			<u>Caucasian</u>	<u>November 7 1899</u>			<u>XXXX</u>	<u>81</u>	YRS	MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<u>West Virginia</u>			<u>U.S.A.</u>						<u>Garrett</u>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<u>Oakland</u>			<u>Cuppett + Weeks Nsg Home</u>			<u>Housewife</u>			<u>Home</u>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS							
<u>Maryland</u>		<u>Garrett</u>		<u>Oakland</u>		<u>36 W. Liberty St.</u>							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<u>BENjamin</u>					<u>Shannon</u>	<u>MARY</u>			<u>Minutes</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for item 18 and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				
<u>XXXXXX No</u>			<u>232-01-1340</u>			<u>B</u>			<u>Firebetal Thrombosis</u>				
4292			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Basilar Artery Thrombosis</u>						Days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) <u>Amputative CV Disease</u>						Years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>14</u> CITY OR TOWN <u>May</u> COUNTY <u>EI</u> STATE <u>MD</u>							
22a. I certify that (I) <u>XXXXXX</u> attended the deceased from <u>5/27/81</u> , 19 <u>81</u> to <u>5/27/81</u> , 19 <u>81</u> , that (II) <u>XXXXXX</u> saw the deceased alive on <u>5/27/81</u> , 19 <u>81</u> , and that in (my) <u>XXXXXX</u> opinion death occurred on the date and hour and from the causes stated above. (II) <u>XXXXXX</u> did not view the body after death.													
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			B. L. Grant, MD			22e. ADDRESS			<u>5/27/81</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN <u>Oakland</u> COUNTY <u>Garrett</u> STATE <u>Maryland</u>				
burial			<u>5/29/81</u>			<u>Oakland Cemetery</u>							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<u>Bradley A. Stewart</u>			<u>Oakland, Maryland 21550</u>			<u>JUN 3 1981</u>							

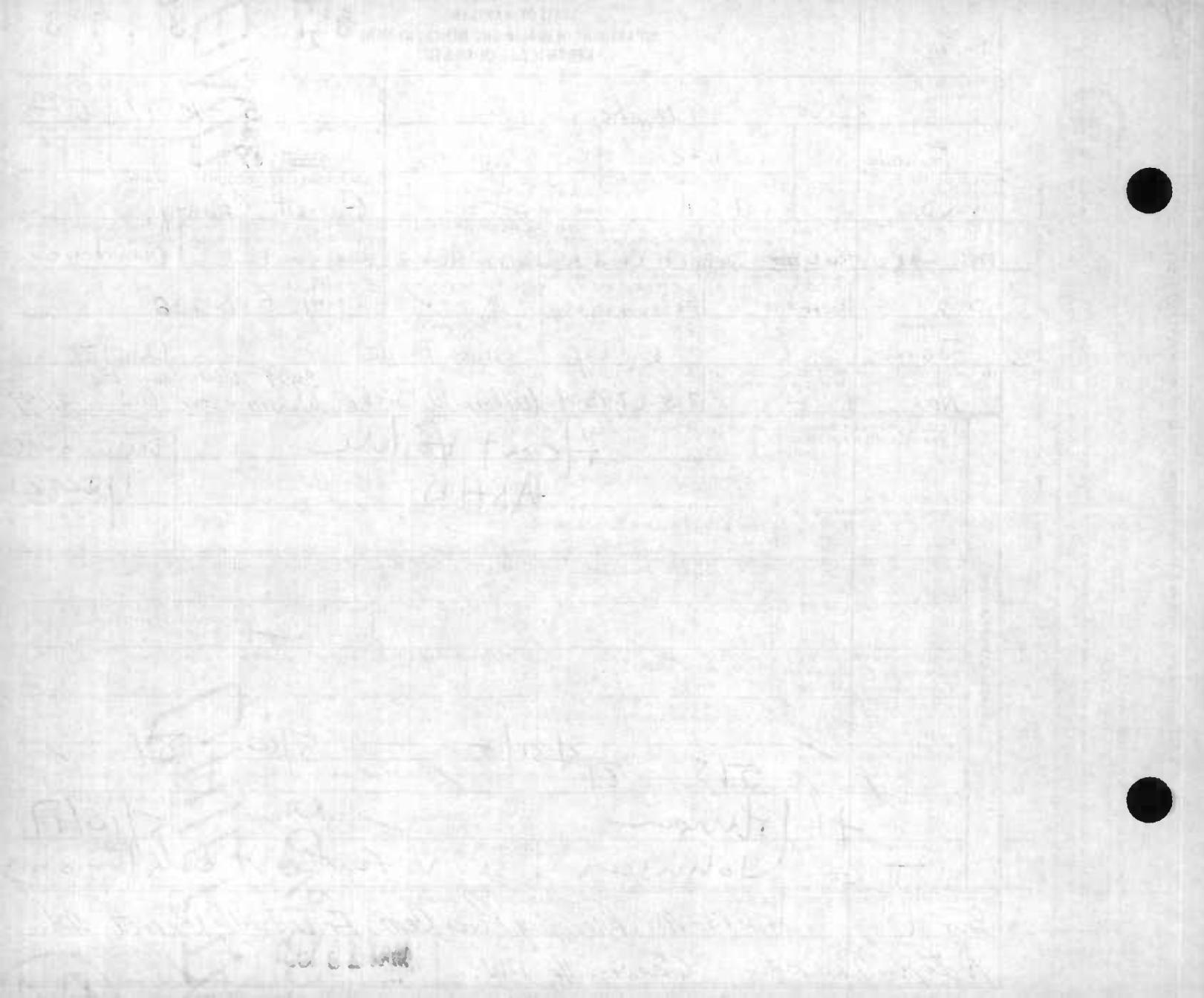


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 13413	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Ida. Blanche Susie.						5 - 10 - 81			9 ¹⁰ M	
3. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female			White			4 28 92							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Garrett County, MD.				
MD.			U.S.A.										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Mt. Lake Park			Dennett Road Nursing Home			Housewife			Own Home				
13a. STATE MD.			13b. COUNTY Garrett			13c. CITY OR TOWN Friendsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS RT #1 Box 238	
14 FATHER'S NAME James			MIDDLE O			15. MOTHER'S MAIDEN NAME Riley						LAST Wolfe	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No -			17. INFORMANT Wilbur O. Sisker			ADDRESS 3227 Nicholson Rd. Westminster, Md. 21157				
PART I. DEATH WAS CAUSED BY: 4140			IMMEDIATE CAUSE (a)			Heart failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF ASHD						years	
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 31/31/81, 1981, to 5/10/81, 1981, that (I) (we) last saw the deceased alive on 5/15/81, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE T.G. Johnson			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/10/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.G. Johnson			22e. ADDRESS 311 W. Faust St. Oskar's Pub, Inc.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-13-1981			23c. NAME OF CEMETERY OR CREMATORIAL Blooming Rose Cem.			23d. LOCATION CITY OR TOWN Friendsville, Garrett, Md.				
24. FUNERAL DIRECTOR NAME Nogard Funeral			ADDRESS Grantsville, Md.			25a. DATE REC'D. BY REGISTRAR 5-15-81			25b. REGISTRAR'S SIGNATURE Nogard				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					81 13414		
					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR	
James		-n-	SKEWERIS		May 5, 1981		1:10 AM
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS
Male		White	July 21, 1891		89	YRS.	MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Lithuania		USA			Garrett MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Oakland		Garrett County Memorial Hospital			Coal Miner		Mining
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS
Md.		Garrett	Oakland				Route #3, Box 164
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE LAST
(UNKNOWN)			Skeweris				(UNKNOWN)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
No		232-09-0474		Walter Skeweris, See #13 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, Sobar, left</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 4810 1 week							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Arteriosclerosis - Peripheral Vascular Disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <i>July 1957</i> to <i>May 5, 1981</i> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <i>May 4, 1981</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <i>Herbert H. Leighton, MD.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>5 May 81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Herbert Leighton		22e. ADDRESS Oakland, MD 21550					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/7/81		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery		23d. LOCATION CITY OR TOWN Thomas, Tucker, West Virginia	
24. FUNERAL DIRECTOR NAME Bradley A. Stewart		ADDRESS Oakland, Maryland 21550		25a. DATE REC'D. BY REGISTRAR MAY 12 1981		25b. REGISTRAR'S SIGNATURE <i>Bradley A. Stewart</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of her death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

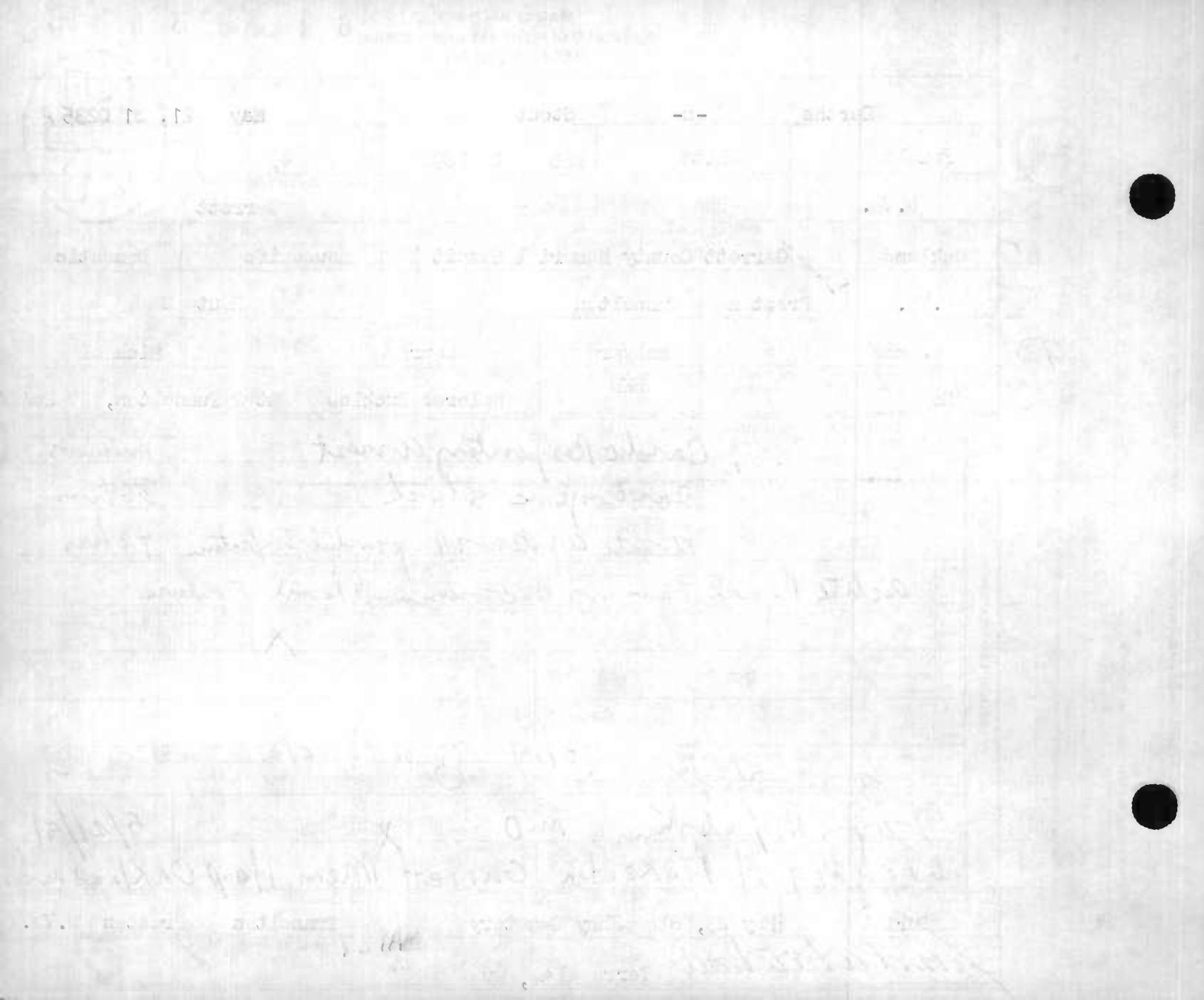
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Bertha			-n-	Stout		May	21	81	0235 A M		
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White	Feb	2	1898	83	YRS	MONTHS	DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett					
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. STATE W.Va.		13b. COUNTY Preston	13c. CITY OR TOWN Tunnelton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2					
14. FATHER'S NAME FIRST James		MIDDLE	LAST Bolyard	15. MOTHER'S MAIDEN NAME FIRST Laura		MIDDLE	LAST Michael				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. UKN		17. INFORMANT Delores Bucklew		ADDRESS Rt 2 Tunnelton, WV 26441					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (c) acute anterior myocardial Infarction 48 hrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) acute Renal Tubular Necrosis and renal Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5/2/81		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/2/81 19 81 to 5/2 19 81, that (I) (we) last saw the deceased alive on 5/2/81 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.											
22b. SIGNATURE Gregory N. Pinkerton		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 5/21/81					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Gregory N. Pinkerton		22g. ADDRESS Garrett Mem. Hosp Oakland Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 23, 81		23c. NAME OF CEMETERY OR CREMATORY Shay Cemetery		23d. LOCATION CITY OR TOWN Tunnelton		23e. COUNTY Preston		23f. STATE W.Va.	
24. FUNERAL DIRECTOR John Whitehead		25. ADDRESS Terra Alta, WVa.		26. REG'D BY REGISTRAR						27. REGISTRAR'S SIGNATURE	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 3.4 6		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
Ferdinand (none) TURNER						May			9th	1981	8 A			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			M		
Male			Black			5 MONTH 10 DAY 1923			57 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			9 GARRETT MD.		
S. Carolina			USA						Garrett					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Oakland			Bennett Road Manor Nursing Home			Laborer			Auto					
13a STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
D.C.						Washington						2333 Edson Place, N.E.		
14 FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST						LAST		
James			Turner			Elsie						Johnson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			4919 A St. S.E.		
No			250-16-6990			John R. Turner			Washington D. C.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cortical atrophy													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from 3-10-1980 , 19, to 5-8-81 , 19, that (I) (X) lost the deceased alive on 5-1-1981 , 19, and that in (my) (X) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did) (X) not view the body after death													22c. DATE SIGNED 5-9-1981	
22b. SIGNATURE <i>James H. Feaster</i>			DEGREE B. S. -			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 107 S. 2nd. St., Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 5/14/81			23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery			23d. LOCATION CITY OR TOWN Oakland			COUNTY Garrett	STATE Md.	
24. FUNERAL DIRECTOR NAME <i>Robert M. Durst</i>			ADDRESS Oakland, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Robert M. Durst</i>					
DHMH-16 50M 7/77 (VR A 15 (4))														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	13	4	1	7		
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR					
Anna Catherine W WENCK						05 - 30 - 81					81	0220 A					
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female			White	Mont th April 25 Year ⁸⁹			84			MONTHS	DAYS	HOURS	MIN.				
7b COUNTRY BIRTHPLACE			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD					
W.Va.			U.S.A.						Garrett County								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Oakland			Garrett Co. Memorial Hosp.			Housewife											
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS							
W.Va			Tucker		Thomas					Brown St.							
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
Thomas			Mary														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS								
No			233-03-0040			Joseph Borshnick			Cleveland, Ohio								
18 CAUSE OF DEATH (Enter only one cause per line for item 18, Part I, and 18b) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma - lung</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus</i>																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <i>Dr. Andrew E. Mance</i>															DEGREE		
22c ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															22d. DATE SIGNED <i>31 May 81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS														
Dr. Andrew E. Mance																	
23a BURIAL/CREMATION, REMOVAL (SPECIFY)			23b DATE June 2, 1981			23c NAME OF CEMETERY OR CREMATORIUM Mt. Calvary			23d LOCATION Thomas Tucker			23e COUNTY W.Va.					
24 FUNERAL DIRECTOR NAME <i>L. Scott Thimble</i>			ADDRESS <i>307 1/2 186 Davis, W.Va.</i>			24b DATE REC'D. BY REGISTRAR <i>26 May 81</i>			24c JUN 1 1981			24d REGISTRATION NO. <i>Longfellow</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 3 4 8										
										REG. NO.										
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			May 24, 1981			8:15 P M											
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										
Female		White		Feb. 20, 1900			81													
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Garrett			10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garr. Co. Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a STATE W. Va.		13b COUNTY Preston		13c CITY OR TOWN Aurora			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS Box 1										
14. FATHER'S NAME FIRST Henry MIDDLE High LAST			15. MOTHER'S MAIDEN NAME Elizabeth			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO.			17 INFORMANT Mrs. Norma Harsh			18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			19c DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Heart Disease			19d DUE TO, OR AS A CONSEQUENCE OF (c) Age			19a DATE OF OPERATION 5/15/81			19b CONDITION FOR WHICH OPERATION WAS PERFORMED Permanent Gastrostomy for Dysphagia			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia Starvation Syndrome due to severe Dysphagia and Carcinoma of Colon			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) this hospital attended the deceased from 5/13/81 to 5/24/81, that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.			22b TIME			22c DATE SIGNED 5/24/81			22d PHYSICIAN'S NAME Gregory N. Pinkerton			22e ADDRESS Box 8 Eylon WVa								
23a BURIAL, CREMATION, REMOVAL (SPECIES)			23b DATE Burial 5/27/81			23c NAME OF CEMETERY OR CREMATORIAL Aurora Cemetery			23d LOCATION CITY OR TOWN Aurora COUNTY Preston STATE W. Va.											
24 FUNERAL DIRECTOR NAME Robert M. Durst			25a DATE REC'D. BY REGISTRAR 5/27/81			25b REGISTRAR'S SIGNATURE														
ADDRESS Oakland, Maryland																				

